Kenwood
ALLERGY & ASTHMA CENTER, P.C.

Dr. Pamela A. Georgeson
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30170 23 Mile Road
Chesterfield Township, MI 48047

Dr. Mark L. Decco
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17965 Hall Road
Macomb, MI 48044

Appointment Date: _____ **Patient's Name**: _____

Birth Date:_____ Age: _____ Male: _____ Female: _____

Single_____ Married_____ Widowed_____Divorce_____ Child_____

Address: _____ City_____

State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave messages/text messages? Yes or No

E-mail Address: _____ Ethnicity: _____

Patient's Occupation: _____ Patient's Employer:_____

Employer's Address: _____

Person responsible for account if other than patient: **Note: Anyone 18 years or older is responsible for payment.**

Full Name: _____ Relationship to Patient: _____

Address: _____ City_____

State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer's Phone #: _____

Step Parent Name(s): _____
Divorced Parents: It is the office policy that the parent accompanying the child will be responsible for all bills.

EMERGENCY CONTACT: _____ Relationship to Patient:_____

Phone #: _____

Referred By: _____

Family Physician: _____ **Phone #:** _____

Pharmacy Name: _____ **Phone #:** _____

Insurance: Please give us all the pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, please supply information for both:

Primary Insurance Name: _____ Group #: _____

Contract #:_____ Effective Date:_____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____

Secondary Insurance Name: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____

Subscriber Employer: _____

INFORMED CONSENT FOR TREATMENT

Please read the following statemtents carefully. Ask any questions which will help you understand them. Your signature at the bottom of this form indicates agreement with each statement, and gives us permission to provide services as indicated below:

I authorize Kenwood Allergy and Asthma Center, PC to provide treatment to me or my legal dependent. I understand that treatment does require a mutually agreed upon plan of service and that my participation is essential. I understand that through the course of treatment, my physician will assist me in understanding procedures, possible risks, and purpose of treatment. I understand that I may withdraw my consent to treat at any time, but I will notify Kenwood Allergy and Asthma of my intent to do so. I further understand that I must comply with the treatment plan in order to receive continued services from the provider. I understand that information will be made available to me regarding my rights and responsibilities. I will be given the opportunity to ask questions about policies and service of the providers at Kenwood Allergy and Asthma Center and will receive a copy of this signed consent form if I so request.

My provider will inform me that he/she recommends that I receive medications listed in my medical record for the treatment of my symptoms. The provider will explain the risk of possible side effects. Although the provider will discuss the most common side effects associated with this/these medications, I understand that I may experience other side effects. I further understand that I should promptly contact my provider if there are any unexpected changes in my condition. I understand that I may not be compelled to take this/these medications and that I may request it to be discontinued at any time. However, I recognize that if I stop the medication, I may experience serious side effects and therefore I should consult with my provider before making such decisions. I also understand that although my provider believes that this medication/s will help me, there is no guarantee that it will be effective in the treatment of my particular symptoms. On this basis I authorize my provider to administer this/these medication/s at such intervals as he/she prescribes.

Print Name:_____Legal/Responsible Party Relationship to Patient:_____

SIGNATURE (Legal/Responsible Party): _____ Date:_____